Race: (please circle)

White Black

Asian Hispanic

Other

Field Pediatrics, P.C.

1106 Gleneagles Drive
Huntsville, Al 35801

I. GENERAL INFORMATION

A. Child's Name _____ Nickname _____ Sex M F
(Last) (First) (Middle) (Circle)

B. Date of Birth _____ Place of Birth _____

C. School (or daycare) Attending _____ Grade _____

D. Child's Previous Physician _____ Obstetrician _____

E. Child's Primary Caretaker: ( ) Parents ( ) Mother ( ) Father Other _____

F. Child's Home Address _____
City _____ State _____ Zip _____
Primary Phone ( ) _____ Landline ( ) or Cell ( )
Secondary Phone ( ) _____ Whose phone? _____
Emergency Contact (other than parent) Name: _____ Phone: _____
Relationship _____

G. Father's Name _____ Date of Birth _____
(Last) (First) (Middle)
Marital Status: M S D W
Employed By: _____ How Long? _____
Occupation _____ S.S. # _____
Business Address: _____
Business Phone #: ( ) _____ Cell Phone #: ( ) _____
Home Address If Different From Child's _____

H. Mother's Name _____ Date of Birth _____
(Last) (First) (Middle)
Marital Status: M S D W
Employed By: _____ How Long? _____
Occupation _____ S.S. # _____
Business Address: _____
Business Phone # ( ) _____ Cell Phone # ( ) _____
Home Address If Different From Child's _____

I. Other Adult in Home _____ Date of Birth _____
(Last) (First) (Middle)
Relationship to Child _____
Home / Business Phone # ( ) _____/_____ Cell Phone # ( ) _____

J. If you have lived in this area less than one year, what was your previous address? _____
_____

K. Person Responsible for account: _____ Relationship _____

L. Insurance Carrier _____ Contract # _____
Secondary Insurance _____ Contract # _____

M. Who referred you to us? _____

II. BIRTH HISTORY: Circle "Yes" or "No", or the correct words, fill in blanks, and explain any "Yes" answers below.

A. Did mother smoke, drink alcohol, or take any medications during the pregnancy? Yes / No
B. Were there any problems during the pregnancy? Yes / No
C. Your child was born _____weeks early / late, or within one week of expected?
D. Were there any problems with the delivery? Yes / No Birth Weight? _____# _____oz
E. Type of delivery: Vaginally head first or breach; or by C-Section?
F. Were there any problems during the newborn hospital stay? Yes / No
G. Your child stayed _____days in the hospital before coming home?

_____

_____

_____

III. DEVELOPMENTAL HISTORY: Rolled over at _____ months; Sat at _____ months; Crawled at ____ months; Cruised (walking holding onto things) at _____ months; Walked at ____ months; Meaningful Words at ____ months; 3 Word Sentences by ____ months; Toilet trained by ____ months; School Performance _____

IV. FAMILY HISTORY:

Sibling names: _____ _____ _____ _____

Age / Sex _____/_____ _____/_____ _____/_____ _____/_____

Birth Date _____ _____ _____ _____

If any family members (including this child) have or had the following problem (s), check and explain below. You may abbreviate relations to patient as follows: F for father, M for mother, PGM for paternal (father's) grandmother, MGF for maternal (mother's) grandfather, MA for maternal aunt, MU for maternal uncle, etc.

( ) Seizures / Epilepsy	( ) Kidney Disease	( ) Eczema / Skin Disease
( ) Mental Retardation	( ) Muscle or Bone Disease	( ) Growth Disorders
( ) ADHD or Autism	( ) Liver Disease / Jaundice	( ) Cancer
( ) Anxiety/Depression	( ) Heart Disease	( ) Sickle Cell Disease
( ) Dementia	( ) Asthma or Wheezing	( ) Anemia
( ) Other Mental Illness	( ) Hay Fever or Allergies	( ) Free Bleeder
( ) Thyroid Disease	( ) Drug Allergy or Reaction	( ) Diabetes
( ) Migraines	( ) Cystic Fibrosis	( ) Other

_____

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